950 CREDENTIALING AND RE-CREDENTIALING PROCESSES

Overview

This policy covers credentialing, temporary/provisional credentialing and re-credentialing policies for both individual and organizational providers.

Credentialing Individual Providers

The Contractor must have a written system in place for credentialing and re-credentialing providers included in their contracted provider network.

1. Credentialing and re-credentialing must be conducted and documented for at least the following contracted health care professionals:

    a. Physicians (MDs, DOs and DPMs)

    b. Nurse practitioners, physician assistants or certified nurse midwives providing primary care services, including prenatal and delivery services

    c. Dentists

    d. Psychologists (master's level and above)

    e. Affiliated Practice Dental Hygienists, and

    f. Independent behavioral health professionals who contract directly with the Contractor.

2. The Contractor must ensure:

    a. The credentialing and re-credentialing processes do not discriminate against:

        (1) A health care professional, solely on the basis of license or certification, or

        (2) A health care professional who serves high-risk populations or who specializes in the treatment of costly conditions.

b. Compliance with Federal requirements that prohibit employment or contracts with providers excluded from participation under either Medicare or Medicaid.

3. If the Contractor delegates to another entity any of the responsibilities of credentialing/re-credentialing or selection of providers that are required by this chapter, it must retain the right to approve, suspend, or terminate any provider selected by that entity and meet the requirements of Policy 910 of this Chapter regarding delegation. The QM/PI committee or other peer review body is responsible for over-site regarding delegated credentialing or re-credentialing decisions.

4. Accreditation of the Contractor, specific to its line of business serving AHCCCS members, by the National Committee for Quality Assurance (NCQA) or the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) will demonstrate that credentialing and re-credentialing requirements have been met.

5. If the Contractor is not accredited as described above (4) at a minimum, the standards outlined in this Chapter must be demonstrated through the Contractor policies and procedures. Compliance will be assessed based on the Contractor policies and standards in effect at the time of the credentialing/re-credentialing decision.

6. Written policies must reflect the scope, criteria, timeliness and process for credentialing and re-credentialing providers. The policies and procedures must be reviewed and approved by the Contractor's executive management, and

   a. Reflect the direct responsibility of the Medical Director or other designated physician for the oversight of the process and delineate the role of the credentialing committee

   b. Indicate the use of participating network providers in making credentialing decisions, and

   c. Describe the methodology to be used by Contractor staff and the Contractor Medical Director to provide documentation that each credentialing or re-credentialing file was completed and reviewed, as per (1) above, prior to presentation to the credentialing committee for evaluation.

7. Contractors must maintain an individual credentialing/re-credentialing file for each credentialed provider. Each file must include:

a. The initial credentialing and all subsequent re-credentialing applications

b. Information gained through credentialing and re-credentialing queries, and

c. Any other pertinent information used in determining whether or not the provider met the Contractor's credentialing and re-credentialing standards.

8. Contractors must implement policies and procedures for initial and subsequent monitoring visits to the offices of primary care providers (PCPs), Obstetricians/Gynecologists and high volume specialists (50 or more referrals per contract year), at least every three years, in accordance with section 940(1)c of this Chapter. As evidence of standard compliance, Contractor must:

   a. Review and document findings regarding medical record keeping practices, and

   b. Assure compliance with Contractor's medical record review standards.

Initial Credentialing

At a minimum, policies and procedures for the initial credentialing of physicians and other licensed health care providers must include:

1. A written application to be completed, signed and dated by the provider that attests to the following elements:

   a. Reasons for any inability to perform the essential functions of the position, with or without accommodation

   b. Lack of present illegal drug use

   c. History of loss of license and/or felony convictions

   d. History of loss or limitation of privileges or disciplinary action

   e. Current malpractice insurance coverage, and

   f. Attestation by the applicant of the correctness and completeness of the application.

2. Minimum five year work history

3. Drug Enforcement Administration (DEA) or Chemical Database Service (CDS) certification

4. Verification from primary sources of:

   a. Licensure or certification

   b. Board certification, if applicable, or highest level of credentials attained

   c. Documentation of graduation from an accredited school and completion of any required internships/residency programs, or other postgraduate training, if the Contractor lists physician schooling information in member materials or on their web site

   d. National Provider Databank (NPDB) query or, in lieu of the NPDB query, all of the following must be verified:

      (1) Minimum five year history of professional liability claims resulting in a judgment or settlement, and

      (2) Disciplinary status with regulatory board or agency, and

      (3) Medicare/Medicaid sanctions.

      (4) State sanctions or limitations of licensure

5. Behavioral health providers and affiliated practice dental hygienists may request a copy of their transcript or proof of education from their educational institution and deliver it themselves in a sealed envelope from the educational institution.

6. Affiliated practice dental hygienists must provide documentation of the affiliation agreement with an AHCCCS registered dentist.

7. Initial site visits for applicants (includes all licensed independent practitioners, including behavioral health care providers and excludes affiliated practice dental hygienists.)

8. Contractor must conduct timely verification of information, as evidenced by notification of provider of approval status within 180 days of receipt of complete application. Contractor must also enter all required information in to Contractor's information system to allow timely claim processing.

Temporary/Provisional Credentialing

Contractors must have policies and procedures to address granting of temporary or provisional credentials when it is in the best interest of members that providers be available to provide care prior to completion of the entire credentialing process.

Temporary, or provisional, credentialing is intended to increase the available network of providers in medically underserved areas, whether rural or urban.

The Contractor must follow the "Initial Credentialing" guidelines 1 through 5 when granting temporary or provisional credentialing. The Contractor shall have 14 days from receipt of a complete application, accompanied by the minimum documents identified above, within which to render a decision regarding temporary or provisional credentialing. Once provisional/temporary credentialing is approved, provider information must be entered into the Contractor's information system to allow payment to the provider effective the date the provisional credentialing is approved.

The Contractor must follow the "Initial Credentialing" guidelines 1 through 8 to complete the credentialing process following the granting of temporary or provisional credentials.

For consideration of temporary or provisional credentialing, at a minimum, a provider must complete a signed application that must include the following items:

1. Reasons for any inability to perform the essential functions of the position, with or without accommodation

2. Lack of present illegal drug use

3. History of loss of license and/or felony convictions

4. History of loss or limitation of privileges or disciplinary action

5. Current malpractice insurance coverage, and

6. Attestation by the applicant of the correctness and completeness of the application.

In addition, the applicant must furnish the following information:

1. Work history for past five years, and

2. Current DEA or CDS certificate.

The Contractor must conduct primary verification of the following:

1. Licensure or certification

2. Board certification, if applicable, or the highest level of credential attained, and

3. National Provider Data Bank (NPDB) query, or, in lieu of the NPDB query, all of the following:

    a. Minimum five year history of professional liability claims resulting in a judgment or settlement, and

    b. Disciplinary status with regulatory board or agency, and

    c. Medicare/Medicaid sanctions.

The Contractor's Medical Director must review the information obtained and determine whether to grant provisional credentials. Following approval of provisional credentials, the process of verification and committee review, as outlined in this Section, should be completed.

Re-credentialing Individual Providers

At a minimum, the re-credentialing policies for physicians and other licensed health care providers must identify procedures that address the re-credentialing process and include requirements for:

1. Re-credentialing at least every three years

2. An update of information obtained during the initial credentialing for sections (1) (except 1c), (3) and (4) as discussed in the initial credentialing section of this Policy

3. A process for monitoring provider specific information such as (at a minimum):

    a. Member concerns which include grievances (complaints)

    b. Utilization management information (such as: emergency room utilization, hospital length of stay, disease prevention, pharmacy utilization)

    c. Performance improvement and monitoring (such as: performance measure rates)

    d. Results of medical record review audits (PCPs, OB/GYN, and high volume specialists)

Credentialing Organizational Providers

For organizational providers included in its network (at a minimum including hospitals, home health agencies, nursing facilities, behavioral health facilities and free-standing surgi-centers):

1. Each Contractor must validate, and re-validate, at least every three years, that the organizational provider:

    a. Is licensed to operate in the State, and is in compliance with any other applicable State or Federal requirements

    b. Is reviewed and approved by an appropriate accrediting body or, if not accredited, Centers for Medicare and Medicaid Services (CMS) certification or State licensure review may substitute for accreditation. In this case, the Contractor must verify a review was conducted and compliance was achieved by obtaining a copy of the report, and

    c. Is reviewed and approved by the Contractor's credentialing committee.

2. ALTCS Contractors, in addition, must review and monitor additional organizational providers in accordance with their contract.

Notification Requirement (Limited to Providers)

The Contractor must have procedures for reporting to appropriate authorities (AHCCCS, the provider's regulatory board or agency, Office of the Attorney General, etc.) any known serious issues and/or quality deficiencies that could result in a provider's suspension or termination from the Contractor's network. If the issue is determined to have criminal implications, a law enforcement agency should also be notified.

1. The Contractor must maintain documentation of implementation of the procedure, as appropriate

2. The Contractor must have an appeal process for instances in which the Contractor chooses to alter the provider's contract based on issues of quality of care and/or service, and

3. The Contractor must inform the provider of the appeal process.

ADES/CMDP PCP Credentialing and Re-credentialing Requirements

In lieu of the credentialing requirements identified in this Chapter of the AMPM, AHCCCS will require the Arizona Department of Economic Security/Comprehensive Medical and Dental program (ADES/CMDP) to establish and enforce the following preferred provider network credentialing requirements:

1. All providers must be AHCCCS-registered

2. Providers must be credentialed by another AHCCCS Contractor. CMDP will be responsible for developing the mechanism that verifies credentialing with the other Contractors.

3. For PCPs who are not credentialed by another AHCCCS Contractor, and who are utilized, or expected to be utilized, more than 25 times in a contract year, CMDP must require all of the following:

    a. Proof that the provider is currently credentialed with an NCQA accredited commercial plan

b. An application and signed attestation statement in compliance with NCQA standards, and

c. A curriculum vitae with a minimum five-year work history.

4. If the PCP is not credentialed by a NCQA accredited commercial health plan, CMDP must require all of the following:

a. An application and signed attestation statement in compliance with NCQA standards

b. A curriculum vitae with a minimum five-year work history.

c. A verification of valid licensure

d. A current DEA or CDS certificate, and

e. A malpractice insurance face sheet.